HOW FOSTER CARE CAN WORK FOR DELAWARE'S CHILDREN

Prepared by

THE FOSTER CARE TASK FORCE
Commissioned by
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FOSTER CARE TASK FORCE
EXECUTIVE SUMMARY

Total # of Children

- Annually approximately 1,300 children enter state's foster care
- Any Given Day approximately 700 children in a foster family placement

Most Challenging

- Of the 700, about 75 children are especially difficult to place due to severe behavior or emotional problems and disrupt frequently

 # Foster Homes Total – 490: Of those, -

- DFS Direct-Contracted ~ 360
- Contracted through Private Agencies ~ 130

NOTE: At any given time, there are approx. 50 approved bed spaces with families who do not feel equipped to handle the type of children for whom we need homes.

ISSUES: ***21st Century kids stuck in a 1970's foster care system!***

1. Children entering system today are displaying more violent behaviors, due to more abusive family circumstances
2. Children are often victims of neglect caused by parental active drug addiction
3. Children who do not have basic needs met in first three years of life have attachment difficulties, displayed in challenging behaviors
4. Children are often aggressive and foster families do not feel safe caring for children with such behavior
5. Over the last nine years, the number of foster homes has kept pace with the number of children in care; however, the system has not kept pace with providing foster families with the level of training and support they need to care for the kinds of children entering care
6. Insufficient number of foster families trained and supported to care for the more challenging children.
7. Insufficient support and training for foster families willing to take more challenging children.
8. Inadequate placement options for the harder-to-place children, esp. teenagers
9. Inadequate placement options leads to disrupted placements and re-placements, which further aggravates a difficult situation for the child.

CONCLUSIONS:

1. There are a growing number of children in foster care who are seriously emotionally and behaviorally disturbed. Their needs cannot be met in traditional family foster care.

2. There is a serious shortage of foster families in Delaware with the skills and support to successfully care for children with challenging needs and behaviors.

RECOMMENDATIONS:

New Foster Care Model
Implement new Delaware Model for Foster Care that proscribes 5 levels of care and compensates foster families based on their skills, training, and the specialized services they provide.

Emergency Homes and Uniform Assessments
The model includes emergency homes and uniform assessments to thoroughly assess every child at the beginning of placement to assure best match with foster parents with skills to meet the needs of the child.

Recruitment Efforts
Both general and targeted to increase overall pool of foster families and those willing to become specialized.

3. Children entering care are often placed in foster families far from their own families, schools and communities.

Clusters
Organize foster homes in local clusters and facilitate development of foster parents along the different levels of. Place children in clusters in their community.

4. In addition to the shortage of foster families, there is also a shortage of specialized group homes to meet the needs of challenging youth.

Continuum of Care
Enrich the continuum of care for children needing placement in specialized foster care and specialized group care.

5. Assure that foster families have in place the supports needed to work with and provide skilled parenting for challenging children.

Supports System
Develop the support infrastructure that will enable DSCYF to retain and enhance foster families and to recruit additional foster families.

SUPPORTS NEEDED

- Specialized Training for Foster Parents
- Foster Home Coordinators (3 plus 1 supervisor)
- Variable Rate Compensation for Foster Families based on Levels
- Lower Caseloads for Caseworkers and Coordinators for most intensive level
- Behavioral Specialists (3 contracted professionals)
- Increased Mental Health Supports, including mental health aides, counseling, and training for community-based therapists in working with children in foster care
- After-Hours Crisis Support
- Volunteer Coordinator
- Respite Care
- Structured After-School Programs
- Mentors for Foster Children
- Tutors for Foster Children
- Recreational and Developmental Activities for Children
- Day Programs for Youth Suspended from School

6. Kinship Care provides an important part of a continuum of resources to children. Kinship caregivers need support

Kinship Helpline and Initial Set-up Assistance
Implement the recommendations from the Kinship Care Task Force with program design changes and over time. Implement Helpline Information and Initial Set-up Assistance in year 1.

FOSTER CARE TASK FORCE REPORT

TASK FORCE DIRECTIVE

On January 11, 2001 Governor Ruth Ann Minner created a Foster Care Task Force to provide written recommendations on the following:

- Steps the state should take to recruit quality foster families
- Steps the state should take to retain existing quality foster families
- Steps the state should take to improve the quality of life of children currently living in foster care
- Steps the state should take to eliminate financial barriers to blood relatives caring for children who would otherwise enter foster care.

The Foster Care Task Force members, listed on the cover of this report, met nine times since it began its work in January. As a starting point, the Division of Family Services (DFS) and foster parents presented a status report on issues impacting recruitment and retention of foster families. The Task Force reviewed a previous foster care task force report from 1996. This was an internal task force comprised of DFS staff and foster parents to address the issues regarding a shortage of families and supports to meet the needs of the more challenging children. In addition, Cathy Hamill, as chair of the Senate Kinship Care Task Force, was asked to present a summary of its work.

BACKGROUND INFORMATION

Capacity - More Children, More Complex Needs

Each year, approximately 1,300 Delaware children enter the state's foster care system. On any given day, approximately 700 children are in foster family placement. Of these children, approximately 75 are especially difficult to place due to severe behavioral or emotional problems. Currently there are 490 foster homes in the state: 360 foster families provide services directly with DFS and another 130 families are contracted by DFS (with a small number of those by Youth Rehabilitative Services) through private agencies. Over the last nine years the number of DFS foster homes has kept pace with the number of children in care (attachment 1 and 2). The system, however, has not kept pace with providing foster families with the level of training and support needed to care for the problems foster children are exhibiting. DFS does not have enough skilled foster families capable of keeping the high volume of difficult to place children in the system. At any given time, there are approximately 50 approved bed spaces in families who do not feel equipped to take the type of children for whom we need homes.

Today, more children entering the system display violent behaviors. This can be attributed to the fact that these children have been exposed to more abusive family circumstances. Moreover, children are often the victims of neglect caused by parents who are actively addicted to drugs. Research tells us that children who do not have their basic needs met in the first three years of life tend to have difficulties in attachment. These difficulties display themselves in very trying, challenging behaviors. Often children are aggressive and families do not feel safe caring for children with these type of behavioral problems.

Everyone would very much like to improve the outcomes for children in care. DFS data shows that if a child stays in care longer than one year, the likelihood of multiple family placements increase. By improving training for foster families, among other supports, the Task Force believes the number of multiple placements can be reduced.

Recruitment and Retention

Contrary to the national trend, DFS has been able to recruit families, increasing the number each year. However, many of the families recruited are not able or willing to care for some of the more emotionally and behaviorally disturbed children. DFS has approximately 75 children at any one time who have proven to be very difficult to place. DFS believes the system needs more capacity and more supports to better serve these children.

The primary concerns regarding retention are lack of support services and inconsistent teamwork with foster families. Foster families need to know what is going on with the birth family so they can work with them, what the goal is for the child so they can support the goal, and to be valued for their knowledge and care of the child. Both DFS and foster parents agree that teamwork needs improvement.

The Task Force believes the quality of life of children in foster care is directly related to adequate recruitment and retention of foster families. Sufficient numbers of well-trained and experienced foster families will increase the ability to match children with families who can meet their needs.

In the course of its work, the Task Force looked at several different models of recruitment and retention from other states. In reviewing the numbers of families DFS has been able to recruit and in recognizing that satisfied foster parents are the best recruiters of new foster parents, the Task Force determined that the primary piece of work on which it needed to focus was retention.

Kinship Care

The Task Force considered the work of the Kinship Care Task Force in its discussion of kinship. The Foster Care Task Force supports the concept of kinship care as an additional resource to meet the needs of children at risk. Kinship caregivers report that their most pressing concerns are legal and financial issues, as well as a need for access to information. Discussion revolved around ways to support the needs of kinship providers as well as foster care providers. While the Task Force recognizes the benefits of kinship care, they also recognize the significant cost associated with full implementation of the kinship care program as outlined by the Kinship Care Task Force.

CRITICAL FOSTER CARE ISSUES

1. There are a growing number of children in foster care who are seriously emotionally and behaviorally disturbed. Their needs cannot be met in traditional family foster care.
2. There is a serious shortage of foster families in Delaware with the skills and support to successfully care for children with challenging needs and behaviors.
3. Children entering care are often placed in foster families far from their family, school and community.
4. In addition to the shortage of foster families, there is also a shortage of specialized group homes to meet the needs of challenging youth.

SOLUTIONS

Delaware Foster Care Model

The Task Force liked the Delaware Foster Care Model proposed by the previous task force and decided that updating it for 2001 would be the starting point for the Task Force's work. The Delaware Foster Care Model (Attachment 3) is intended to provide a continuum of care to meet the needs of children in family foster care.

The model begins with the premise that the strengths and needs of all children should be assessed at the beginning of placement so that children can be matched with foster parents who have the skills to meet those needs. The goal is to provide each child with the safety, stability, self-esteem and sense of hope that comes with a single and best foster care placement.

Because we believe that even children with extremely challenging needs do best in families, the continuum needs to be expanded from traditional foster care to include levels of care to meet the levels of need that children exhibit. The model identifies skills and supports foster parents need at every level to maintain stable placements, with particular attention to the skills and supports needed by foster families for children and youth at the highest levels.

Just as every foster child entering care will be assessed, the strengths and needs of every foster family will be assessed. Foster families will then be compensated based on their skills, their training, and the services they provide. This marks a change from the current system which compensates foster parents based on the difficulty of care of the child rather than on the foster parent's skills and willingness to provide additional services.

Although not a category within the model, every child's family will also be assessed on their strengths and needs. This assessment contributes to the family's case plan and the services necessary to reduce the risk to the child. The plan is outcome based and supported through a Family Court order and regular reviews.

Another underlying principle of the model is to develop foster families in the communities where the children live. After the devastation of abuse and neglect and the trauma of separation from family, children need the continuity of relationships with family, peers, significant persons in their lives and familiar places.

Foster Parent Cluster Support

The Delaware Model of Foster Care is accompanied by a plan to organize foster homes into geographical clusters. Each cluster of 12 families would have an emergency home, as well as foster homes able to care for children at different levels along the continuum. In this manner, children would be placed in homes near their birth families where regular visits could occur. There would be minimal disruption to a child's friendships, relationships and education. The foster families within the cluster would serve as a support group to each other. The cluster would take responsibility for the children coming into families within the cluster. Cluster families would provide emergency back-up, respite, baby-sitting, use of community resources and other family supports. If a child disrupts from one family, it is hoped that another family in the cluster would take over, thus minimizing the disruption to the child. A foster home coordinator would be assigned to two clusters of 12 families making their caseload size 24. This cluster model with a foster home coordinator attached would improve communication and teamwork between staff and foster parents.

There are support services that are currently limited or unavailable, but that are necessary to the success of the model. These supports could be considered part of wrap-around services to the child and foster family. The wrap around model of meeting children and family needs is one that has been utilized in other states with positive outcomes for children.

Enriching the Department Continuum of Care

Another area of need is the Department's current continuum of care for children needing placement outside of their homes. Over the years, internal Departmental work groups as well as several consultants have recommended that the continuum of care be enriched. In particular, there is a gap between foster care, group care, and residential treatment. What would help fill in the gap is specialized foster families to be used either from the onset for very difficult children as the model suggests or as a step down from more intensive services such as group care and residential treatment. In addition to specialized foster care, small therapeutic group homes need to be added to the continuum (attachment 4). These small therapeutic group homes would best serve children rated at Level 4 or 5 on the model but their needs are such that they need both the structure and 24 hour supervision provided by such a facility. Often these children have attachment difficulties and have experienced multiple placements. They often cannot tolerate the intimacy of family relationships. Families are often exhausted by their behaviors. These two combinations make small, structured specialized group care a better choice.

RECOMMENDATIONS:

The Task Force believes the best way to improve the quality of care of children in foster care is to adequately recruit and support foster families. Supporting foster families is also the best way to retain them. Because recruitment, retention and improving the quality of life of foster children are intricately connected and rely heavily on the level of support provided, most of the Task Force recommendations emphasize retention through the development and improvement of supports to foster families.

RECOMMENDATION 1: Implement the Delaware Foster Care Model

Specialized training for foster parents - Implementation of the model will require additional training for foster families who wish to build their skills to care for higher level children. DFS believes that most of the 360 foster families would be able to serve level 1 and 2 children. Very few of the current foster families will be able to care for the most intensive children. Workers and coordinators would need the same or complementary training on the same issues. This would also include the purchase of assessment tools for emergency foster families.

Emergency Homes - The model sets out the premise that each child entering care be assessed on their strengths and needs. It is hoped that very young children will be able to be matched to a family immediately. For those children who cannot be immediately matched, the model suggests a number of families be developed to take emergency placements only. These families will be specially trained in handling emergency placements. The families will also be trained in completing screening and assessment tools that will assist DFS in making the next placement the best placement. Approximately 20 beds would be needed statewide. This level of care would be reimbursed at $35/day.

Higher level of foster parent reimbursement consistent with the model levels
(also under supports)
Delaware Foster Care Model
Levels:

Emergency	$35/day
Basic Level 1	$17/day
Moderate Level 2	$17/day plus $8 daily supplement
Intensive Level 3	$17/day plus $18 daily supplement
Intensive Level 4	$17/day plus $28 daily supplement
Intensive Level 5	$17/day plus $38 daily supplement

Staff: Three additional foster home coordinators and one supervisor will be needed to support the model and respond to increased recruitment. Include foster home coordinators in the career ladder to become family crisis therapists to support the more intensive level foster families - This recommendation will support the plan to organize foster families in clusters of 12 making coordinators responsible for two clusters each. Coordinators will obtain additional training to better support children and foster families at the higher levels of care and respond to crisis situations. Foster parents will support each other and provide training, supports, and recreational activities under the leadership of a foster parent cluster leader and the foster home coordinator. Funding is necessary to reimburse the cluster leader for leadership and other cluster activities. Regional staff should have a small budget to arrange for small regular recognition of foster family efforts and successes as well as tokens of appreciation for those families who "retire."

Supports - A number of supports that are currently only minimally available or not yet available will need to be developed. Some of these resources can be obtained at no additional costs through more intensive work with the community and our private agency partners. Others, however, will require funding to develop.

The following supports are those that could be developed in the community at little to no cost if the Volunteer Coordinator is funded (see Recruitment recommendation).

- Mentors
- Funds for recreational and developmental activities for children
- Tutors

The following supports would need exploration and collaboration with other systems. The cost has not been determined.

- Structured after school programs
- Day programs for youth suspended from school
- Increased mental health supports including mental health aides, counseling, and training for therapists in foster care issues

The following supports would need funding to implement:

- Higher level of foster parent reimbursement consistent with the model (see above)
- Behavioral consultants- professionals trained in behavioral intervention who could assist foster families both prior to and during placements of behaviorally challenging children; could provide crisis support (three contracted consultants)
- Crisis support after hours (covered in cluster support and behavioral consultants)
- Increased foster home coordinator support (covered above in staff recommendation)
- Lower caseloads for caseworkers and coordinators at most intensive level of care

RECOMMENDATION 2: Increase recruitment efforts:

Recruitment will need to focus on three areas: emergency families, intensive level families, and adoptive families. The current DFS budget for recruitment is $8,000.00. With that, DFS purchases recruitment supplies and advertising. Recruitment efforts include booths at community events/fairs, advertising in small newspapers, feature stories in newspapers, ads in program books such as the Blue Rocks, radios public service announcements and interviews, and a $100 recruitment bonus to foster parents who recruit a new family.

To keep the message about the need for foster and adoptive families more visible to the public, the recruitment budget will need to be increased. This will contribute to the overall need for foster families and is necessary to purchase such items as public service announcements played during prime times, billboards, and bus side boards. To recruit families with a higher level of skill as the model recommends will require a more intensive, targeted, community-based recruitment strategy.

In order for DFS to respond to increased recruitment, the recommendation regarding the increase in foster home coordinator staff must be implemented.

A Volunteer Coordinator is needed to facilitate additional support resources and recruitment activities. The Coordinator would be responsible for fund raising, developing mentoring programs, enlisting the assistance of volunteers who wish to help in foster care but cannot make the commitment to be a foster parent, supporting foster parent cluster groups as appropriate and assisting the Department in implementing both a general and targeted recruitment strategy.

RECOMMENDATION 3: The Department should both enhance the current residential group homes and fill in the remaining pieces of the continuum of care.

This recommendation includes developing resources to fill in the gaps in the Department's current continuum of out-of- home care resources. Although the Delaware Foster Care Model is intended to serve children in least restrictive settings and develop more specialized families, some children exhibit behavior that requires a more structured and supervised setting than a specialized foster family may be able to provide. Smaller specialized group homes serving no more than 6 children will help provide better options for matching children to appropriate resources.

This recommendation also allows for a small number of specialized foster care beds to be purchased for a targeted population of specialized youth such as youth reentering the community from secure settings used by Youth Rehabilitative Services, sex offenders, or emotionally disturbed children whose plan is adoption.

The current group homes would be able to do a better job managing youth if they were better staffed for the kinds of children who need this level of service. There is a need for more child care staff in the group homes so that the youth can be better supervised. At least one more child care worker is needed at the busiest times when the youth are at home (3-11), one more weekend staff person, and at least one more awake staff at night who could float between cottages or programs. Although the group homes meet the licensing standard for staff to child ratios, the youth often require more attention and supervision than the standard requires.

RECOMMENDATION 4: The Department should assign a small number of workers to small caseloads of intensive level children. A one case manager model should be implemented.

In order for the model to be successful for both the children and the foster families, there must be a smaller worker to caseload ratio. Treatment foster care programs that DFS currently purchases uses a caseload of 1:6. This is consistent with other treatment foster care programs in other states. Senate Bill 142 standards of 19 families (intact and children in-care plus parents) will not provide sufficient support to children in the two highest levels. Most children who would be rated at the more intensive levels of care are active with more than one division within the Department. This means that the child and family have more than one case manager. By employing a one case manager model that stays with the child throughout the child's placement, the Department should be able to reallocate staff to address this recommendation.

RECOMMENDATION 5: The Foster Care Task Force supports the recommendations of the Kinship Care Task Force but suggests changes in the program design.

The Foster Care Task Force believes that a kinship care program would be an important part of a continuum of resources to support children. The Task Force suggests the program be phased in over a three year period. Further additional reductions in cost could be achieved by eliminating the age criteria as an eligibility factor. Rather than setting up a new 800 phone number to provide information to kinship caretakers, the Task Force recommends using the current Delaware Helpline. Due to the special circumstances that kinship providers face, training in resources and supports will be needed for Helpline staff. The Task Force further recommends that funds be appropriated to begin an emergency assistance account for one time home readiness (beds, clothes, etc.) for relative care providers. It is recommended that the Department of Health and Social Services administer this fund. The Task Force is recommending that both of the above occur in the first year at a reduced cost of $60,000 total.

Summary of Improvements Recommended by Foster Care Task Force
5/16/01

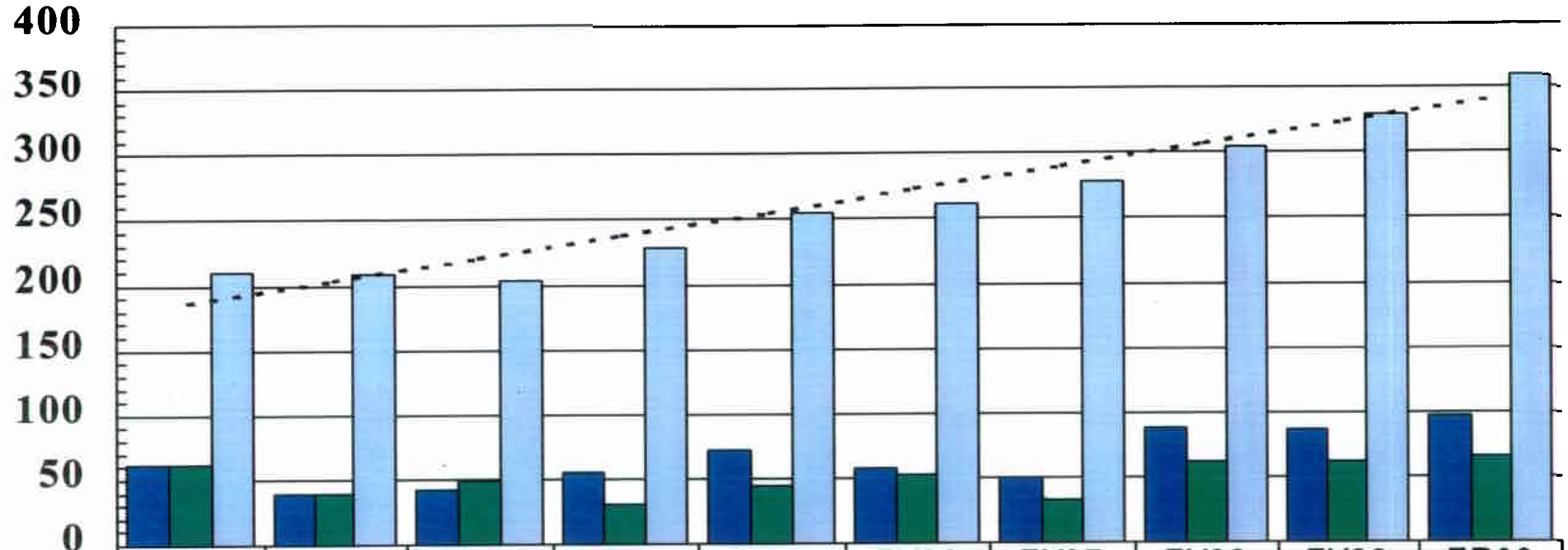
Delaware Foster Care Model Board & Level payment: **Emergency @ $35/day, Basic Level 1 @ $17/day, Moderate Level 2 @ $25/day, Intensive Level 3 @ $35/day, Intensive Level 4 @ $45/day, Intensive Level 5 @ $55/day.**

	Year 1			Year 2			Year 3
	Federal cost	State cost	Total Cost	Federal cost	State cost	Total Cost	Total additional Costs all State Funds
Training *immediate start*	$20,000	$20,000	$40,000	$20,000	$20,000	$40,000	
Foster Home Staff (3 coordinators, 1 supervisor) *10 mo in year 1*	$46,699	$187,100	$233,799	$54,720	$207,200	$261,920	
Career Ladder Upgrade	$11,600	$27,100	$38,700	$11,600	$27,100	$38,700	
Cluster Support *full implement in 1st year*	$7,875	$23,625	$31,500	$7,875	$23,625	$31,500	
Recruitment	$30,000	$70,000	$100,000	$30,000	$70,000	$100,000	
FACTS changes; payment support	$25,000	$25,000	$50,000				
Kinship Helpline, initial set up assistance		$60,000	$60,000		$100,000	$100,000	
Specialized group care *full implement in 1st year, incl one times*	$94,500	$535,500	$630,000	$94,500	$535,500	$630,000	
Additional board & level cost *First year for 3 months plus $17 min rate 7/1/01*	$288,394	$865,181	$1,153,575	$981,960	$2,945,880	$3,927,840	
Emergency Beds *1st year for three mo*	$15,969	$47,906	$63,875	$63,875	$191,625	$255,500	
Behavior specialists *10 mo service in 1st year*	$41,667	$116,667	$158,333	$60,000	$140,000	$200,000	
Volunteer Coordinator *10 mo in 1st year*	$16,680	$55,600	$72,280	$17,910	$62,400	$80,310	
Increased child care staff in group homes *9 mo implementation*	$50,625	$286,875	$337,500	$67,500	$382,500	$450,000	
Specialized foster care *implement in 2nd year*				$45,000	$255,000	$300,000	
Respite *starting in 2nd year*				$7,500	$22,500	$30,000	
DHSS computer changes kinship					$1,000,000	$1,000,000	
Kinship Cash Benefits DHSS *full year, 30% of universe*							$4,800,000
Contracted kinship home assessments & reviews							$1,000,000
Licensing spec for background checks *10 mo*							$50,300
Total Request	$649,008	$2,320,554	$2,969,562	$1,462,440	$5,983,330	$7,445,770	$5,850,300

Prioritized by Task Force to put in the foundation elements of the improvements first, and build on other elements in subsequent years.

DFS Foster Homes

Opened, Closed, Total & Growth Trend line



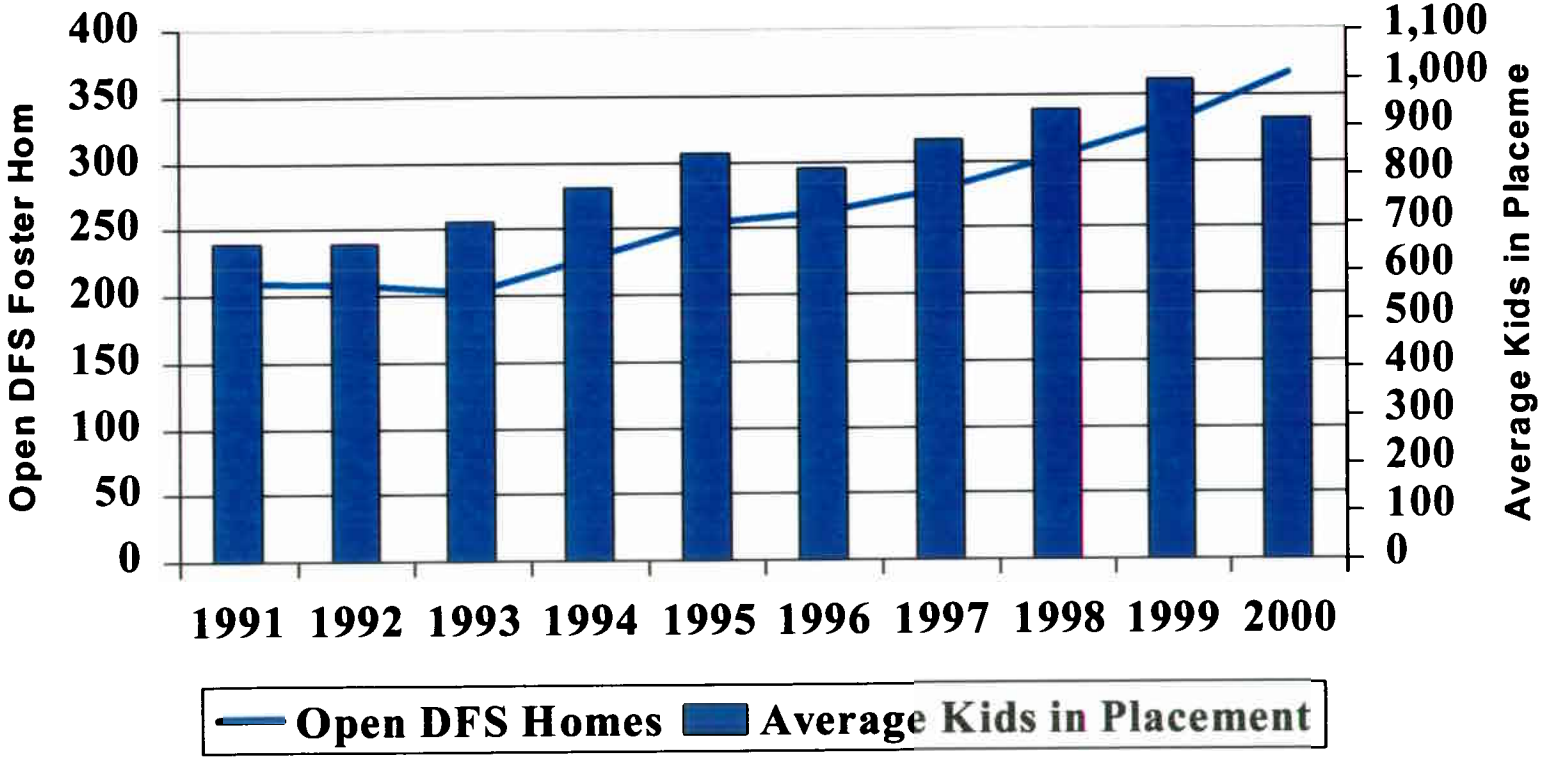
	FY91	FR92	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FR00
Opened	61	39	42	55	72	58	50	88	87	97
Closed	62	40	48	30	45	52	33	62	62	66
Total	210	209	203	228	255	261	278	304	329	360

70% Growth Over Ten Years is counter to national trend

Attachment 1

Foster Homes And Children in Care

The number of DFS Foster Homes has kept pace with the number of children in care



Attachment 2

DIVISION OF FAMILY SERVICES
FOSTER CARE MODEL

Basic Level 1

Children age 0-17 • Show minor or transient episodes of emotional, behavioral or physical problems • Fall within normal developmental levels	Initial Assessment to include: • Physical exam • Developmental screening • Educational screening • Emotional health screening • Foster parent observation and assessment tools administered by foster parents • Team meeting to provide assessment information to foster care staff responsible for matching	Basic needs: • Food • Clothing • Shelter • Supervision • Protection (safety) • Nurturing • Stability • Self esteem • Sense of hope • Connection to birth family and significant others • Permanency • Independent living skills • Education • Each child's plan to meet needs will be individualized & determined by the assessment	Meet the child's basic needs (day to day) • Food, clothing, shelter • Supervision • Protection • Nurturing • Stability Meet developmental needs • Physical • Emotional • Educational • Cultural • Social • Spiritual developmental • Address delays • Support connections with birth family & significant others • Facilitate visits • Support permanency plan • Participate in team-planning meetings • Attend school meetings • Arrange medical & dental appointments • Maintain life book • Provide recreational activities • Participate with child in mental health counseling as appropriate • Transportation • Teach independent living skills	• Foster PRIDE • First Aid & CPR • Module I - meeting the developmental needs of children at risk (12 hours)	$17/day • Medicaid (medical & dental coverage) • Foster Home Coordinator support • Mentors • Mental health counseling • Day care (employment related) • Respite care (10 days) • Funding for child's recreational, developmental activities • Crisis support after hours • Support group for children • Support group for foster families • In-home behavioral consultation as needed	• ↑ Availability of mental health • Counseling therapists trained in foster care and abuse/ neglect issues • ↑ Capacity for in-home consultations • ↑ Respite homes • ↑ Respite funds community support for mentors • ↑ Foster home coordinators for 1:24 • ↑ Crisis support after hours

Moderate Level 2

CHARACTERISTICS OF CHILDREN	ASSESSMENT	CHILD'S NEEDS	SERVICES REQUIRED of the FOSTER FAMILY	TRAINING	SUPPORTS	SYSTEMS NEEDS
• Children age 0-12 • Special education • Demands excessive attention • Mild to moderate developmental disabilities • Mild to moderate impulsive behavior and/or hyperactivity • Drug exposed babies • Emotionally disturbed, depressed, withdrawn • HIV (Symptomatic)	• Same as for Level I • Ongoing assessment of child used in planning 2x year in team meeting • Physical exam (annual) • Dental exam (annual)	• All of Level 1 plus • Additional supervision to keep child safe • Additional supports for education	• All of Level I plus • Accompanies child to appointments • Increased school involvement • Assists in implementing treatment plan • Provides role model for child's family	ll of Level 1 plus • IEP Process and how to access services • Surrogate parent training as needed • Medications • Special training as needed • 12 hours training per year	25 day • All of Level 1 supports plus • Educational supports as needed • 15 days respite care • Access to doctors for medical review as needed • Training for staff re: IEP process and how to access treatment services • Additional caseworker support	Same as Level 1 • ↑ Educational supports (tutoring)

Supports include those on previous page plus additional supports in the column.

Intensive Level 3

Children age 0-17 Must exhibit at least 2 of the following: • Moderate to severe developmental delays • Medical conditions needing constant caretaker attention and multiple doctor's visits (i.e., cerebral palsy, muscular dystrophy, etc.) • Severe impulsive and/or hyperactive behavior • Sexually abused • Encopretic • Eneuretic • Emotionally disturbed • May have had previous psychiatric hospitalizations • HIV (Symptomatic)	• Ongoing assessment used in quarterly team meetings • Physical exam (annual) • Dental exam (annual)	All of Level 1,2 plus • Foster parents with skills to meet child's special needs • Additional supervision to keep child safe	All of Level 2 • Frequent and close communication with caseworker and coordinator • Observes and documents behavioral/ emotional functioning of child • Observes and documents patterns of behavior • Facilitates educational program • Facilitates behavioral change • Quarterly team reviews • Foster parent part of treatment team	All of Level 1,2 plus • 15 hours training per year • Other specialized training as needed • Sexual abuse • Universal precautions	$35 a day All of Level 1&2 supports plus • Case worker/ coordinator support to child and foster family 2x month • Mental health services as needed; may include day hospital • Structured after school program/ activities • 21 day respite • Crisis respite beds • Aides for one-on-one	• Training for caseworker and coordinators to meet special needs of Level 3 children • Structured after school programs for difficult children • Case aides • ↑ Caseworkers coordinator support • Crisis respite beds • Reduced caseload for caseworkers

Intensive Level 4

Children aged 6 - 17 must exhibit at least 3 of the following: • Moderate to severe developmental delays • Moderate to severe impulsive and/or hyperactive behavior • Sexually abused • Encopretic • Enueretic • May have had previous psychiatric hospitalizations or residential treatment • Episodes of delinquent behavior • Run away behaviors • Special ed. and/or other school problems • Episodes of depression and suicidal ideation • Pregnant teen or teen with baby	• Ongoing assessment of child used in quarterly team meetings	All of Level 1,2,3 plus • Additional supervision to keep child and others safe • More frequent more intensive therapy	All of Level 1,2,3 plus • Participates in multidisciplinary meetings • Emphasis is on helping child to function in a less intensive/ restrictive environment • Adapts home environment to meet child's needs	FOSTER PRIDE All of Level 1,2,3 plus • Depression/ suicide • Specialized training as needed • 20 hours per year	$45 per day ll of Level 1,2,3 supports plus • No more than 2 foster children at this level • No more than 4 children total • 21 day respite • Day program for suspended youth needing supervision • Behavioral consultation • Increased caseworker and coordinator contacts (3x month)	• Structured after school program/ activities • Day Program for youth when suspended • Behavioral consultants • Lower case loads for caseworkers and coordinators

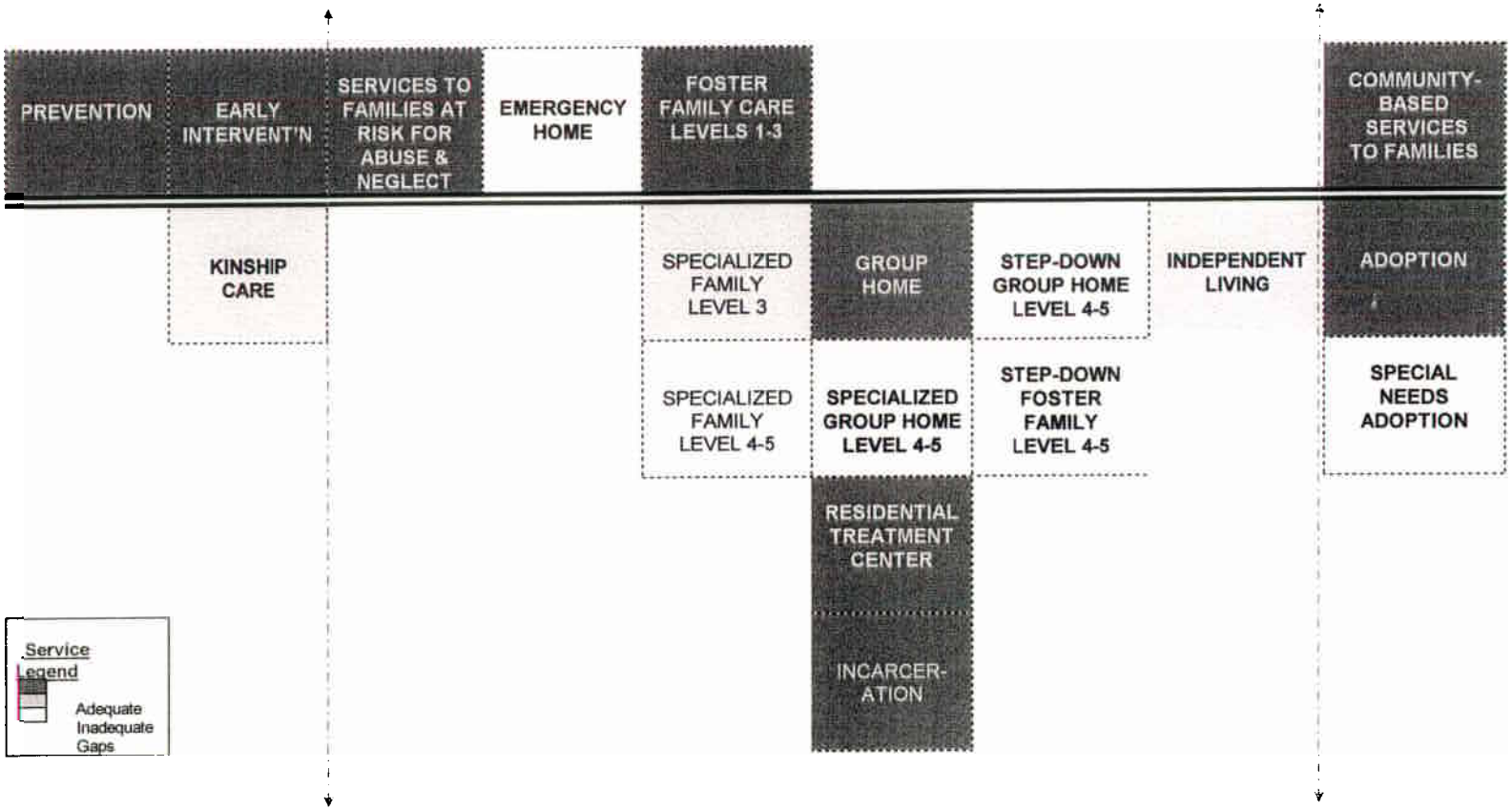
Intensive Levels 5 (Step Down from RTC or Psychiatric Hospital)

Children aged 8-17 Must exhibit at least 4 of the following: • Runs away frequently • History of firesetting • History of suicide attempts • Delinquent behavior • Diagnosed as conduct disorder • School problems and/or truancy • Assaultive behavior • Drug/alcohol use interfering with daily activities • Inappropriate sexual behavior, promiscuity, prostitution • History of failed placements • History of inpatient or residential treatment • Pregnant or teen parents	• Ongoing assessment of child used in monthly team meeting	ll of Level 1,2, 3,4 plus • Additional supervision to keep child and others safe • More frequent more intensive therapy as needed • Behavioral consultation • Gradual step down from RTC or psych-hospital • Aides • Wraparound services at time of placement • Crisis respite beds	ll of Level 1,2,3,4 plus • 1 foster parent or other approved adult with the child at all times • Have authority to call staffing on child • Participates in monthly team reviews and treatment planning	All of Level 1-4 • Restraint training/crisis intervention training • Additional training related to needs of child • 20 hours training per year	55/day ll of Level 1,2,3,4 • Individualized solutions for those youth whose needs are complex and cannot be served within the other resource categories • One child per home • 4x month caseworker contact • Planned respite 30 days/yr. • Wraparound services in place at time of placement	ll of Level 1,2,3,4 plus • lower caseloads for caseworker & coordinator (to offer additional support)

EMERGENCY HOMES

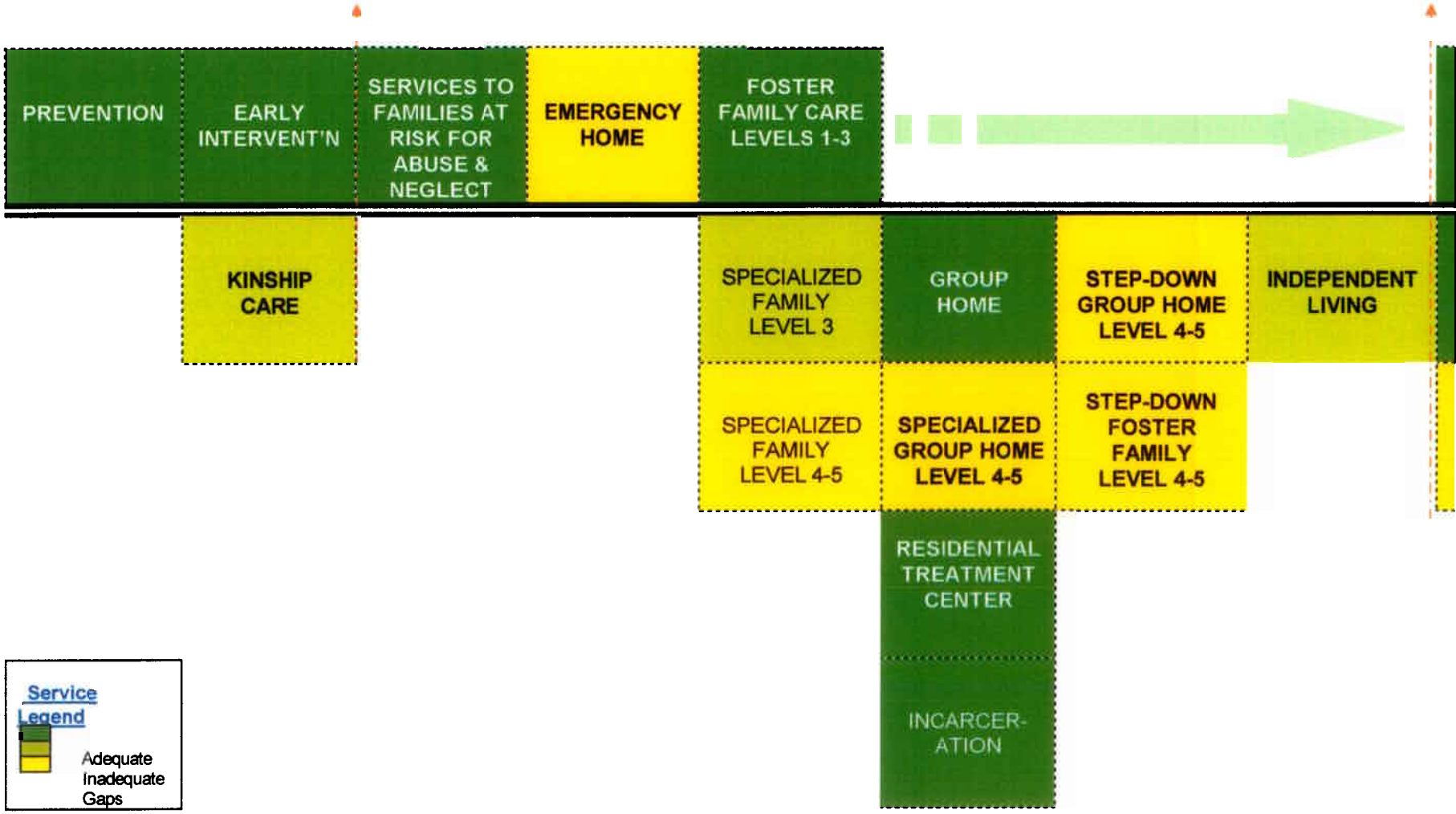
Children ages 0-17 who are entering family foster care	• Physical and medical treatment as necessary • Developmental screening • Educational screening • Emotional health screening • Foster parent observation and assessment instruments administered by foster parents • Additional testing as indicated • Team meeting to provide assessment information to foster care staff matching needs of child to foster family skills	• Assurance of physical safety • Emotional support to child in trauma of separation from family • Information about foster care and what will happen next • Immediate medical needs met • Visits with birth family • Continuity for child as much as possible… same school community • Complete assessment to determine needs and best placement • At the same time foster family and professional staff are assessing needs of child, staff will assess family: • Strengths • Needs • Risks • Some prediction of length of placement	• Physical safety of child • Provide strong emotional support of child in trauma of separation from family • Explain foster care to child in age-appropriate manner • Transportation to/ support through emergency medical treatment • Support connection with birth family by facilitating visits • Maintain continuity for child as much as possible… school, friendships, etc. • Assess child's needs through observation • Administer assessment instruments • Participate in meetings to assess and make recommendations for best placement • Available by phone/pager at all times • Accept youth of all ages/sex/ race for up to 14 days unless family safety is at risk • Provides enriched environment and recreational opportunities	• Three years experience as foster parent or comparable experience • Foster PRIDE • First Aid and CPR • 45 hours of in-service training including: • PRIDE - Module I • Sexual Abuse • Teens • Identifying developmental needs and delays • Medications Depression/ suicide • Specialized training in assessment • 12 hours of in-service training per year required	• In-home consultation with behavioral specialist • 24 hour crisis access • Transportation (as back up) • Foster Care team • Caseworker contact - 1x/week • Foster Home Coordinator contact 2x/month • 5 days per month off	• Behavioral consultants • Financial support to recruit and train • Foster parents for assessment homes • Respite providers for this special population of children • Assessment tools • Access to evaluations as needed

A CONTINUUM OF SERVICES
FOR DELAWARE'S CHILDREN & FAMILIES



Attachment 4

A CONTINUUM OF SERVICES
FOR DELAWARE'S CHILDREN & FAMILIES



Attachment 4